AMWA Connections

The Vision and Voice of Women in Medicine

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AMWA – a place in history and the future

Diane Helentjaris, MD; AMWA President-Elect 2004-2005

Women the majority of medical school applicants for first time

For the first time ever, women outnumbered men among applicants applying to US medical schools for the 2004-2005 academic year. This marks a milestone in the slow but steady increase in the number of aspiring female physicians.

According to the Association of American Medical Colleges (AAMC), 17,672 women applied to medical school, representing an almost 7% rise over last year's total. There was an overall increase of 3.4% in the number of medical school applicants as a result.

Black women applicants increased by almost 10% to 1,904. The number of black applicants overall rose almost 5% to 2,736, but the number of blacks who entered medical school declined by 6% to 1,056.

Hispanic applicants increased by less than 2% to 2,483, while the number who entered medical school declined by almost 4% to 1,089.

"The increase in total and first-time applicants is a reaffirming sign that the current generation of young people recognizes the attractiveness of medicine as a profession," said AAMC president, Jordan J. Cohen, MD; "the decrease in minorities underscores the need for redoubled efforts to attract a critical mass of students from diverse backgrounds in order to enhance the education of all future physicians."

Yen Truong, 23, of San Francisco, a first-year student at Tufts University School of Medicine, said, "Medicine has come to accept that it's not just science, it's more of an occupation of caring. I think that's a positive change, in that women are better served that way, and patients are better served if there are more women doctors."

Diane Helentjaris, MD

Why is AMWA still around? Don't women physicians face the same basic problems as male physicians? Isn't it time we sunsetted this organization and sent it packing down the road with the Women's Christian Temperance Union? Good questions.

Are women physicians different? Research says, "Yes." Women work fewer hours per week "due to domestic responsibilities"; their careers extend longer; they experience more career interruptions; and they spend more time per visit per patient. They are less likely to reach full tenure as faculty or to be the dean of a medical school. Until all girls who dream of becoming a doctor can achieve their goal without a nagging sense that they have been held back or otherwise treated unfairly due to their gender, the American Medical Women's Association must continue.

But isn't women's health a "done deal"? Haven't we worked all that out, and aren't we on the right road now? Everyone talks about women's health. Ads in magazines sell it. Even the federal government has special programs for its study. Again, women's health is probably not done yet. Things are certainly improved, but this foal's still on wobbly legs. The science of women's health is incomplete. Even when knowledge exists, implementation can be lacking. For example, women and their physicians are not sensitized to their risk for cardiovascular disease. The diagnosis is missed and women suffer or die. Attitudes toward sexuality hinder women's health. The risk of HIV/AIDS to women is increasing, both nationally and globally. We still bear the greater burden in controlling our reproduction. Female contraceptive choices are expanding almost weekly. (Would you like to use a patch, a pill or a shot? Do you want to have a period once a month, once a quarter, or once a year?) Yet, when was the last breakthrough in male contraceptives?

Women experience American health care policy in a disparate way. The new plan to extend Medicare to cover prescription costs includes its partial privatization. Higher income Medicare recipients are targeted for this privatization; lower income folks will stick with the government. With their longer life span, women will have greater exposure to the fruits, rotten, ripe or good, of this policy change. With their lower income (because of absences from the workforce to raise families and generally lower wages), these women may now find themselves disproportionately experiencing the cheap side of any modified Medicare program.

Other state and federal health care policies create risks for women. For example, low-income pregnant women who are "undocumented aliens" may find that state Medicaid policies will fund the delivery of their babies but not prenatal care. Their children will be citizens, and as such, the birth garners government support. The mother's well-being is not so cherished. Immigrant mother's lives are put at risk when they are forced by poverty and policy to forego the most basic prenatal care.

These are a few examples of important problems that require our energy. We all work and live for the day that the need for the American Medical Women's Association ceases, but as for now, we have work to do! Get educated on these important issues! Get active! Get going!

Gender equity

Challenges to women's leadership in academic medicine

Claudia Morrissey MD, MPH, Associate Director of the University of Illinois at Chicago (UIC) Center for Research on Women and Gender and the Director of the UIC Women in Science and Engineering programs. Dr. Morrissey has organized and directed the *Beyond Parity* conference to examine women's leadership in academic medical centers throughout the US.

Challenges

Although the number of women enrolled in medical school has increased dramatically over the last 30 years, approaching parity, women's entry and advancement in academic medicine has been slow. Between 1995 and 2001, the proportion of full-time women faculty members increased by a mere 3%, from 25% to 28%. And, these female academic physicians consistently lag behind their male counterparts in terms of remuneration, promotion, and tenure regardless of their number and accomplishments. Examine the faculty cohort appointed in 1980 eleven years later, and you find that 83% of men have achieved associate or full professor status versus only 59% of women. In top leadership positions the absence of women is even more glaring with numbers at token levels – 12% of full professors, 8% of academic department chairs, 6% of deans.

This stubborn persistence of differential advancement has led to rethinking what was previously perceived as simply a pipeline problem: too few women entering medicine leading to too few choosing academic medicine; too few achieving distinction in their fields; too few interested in tenure and leadership positions. Clearly there are other dimensions to this problem beyond the oft-claimed scarcity of "qualified" women.[1]

Academic medicine clings to these antiquated norms and arcane processes at its own peril; lack of diversity in leadership stifles innovation and creativity.

Increasingly, attention is being directed toward the operations and culture of medical academe itself, a system, like others, that rewards or marginalizes to preserve the status quo.[2] Women faculty are negatively affected by system inertia in several ways. First, the norm that assumes unlimited time for professional endeavors differentially disadvantages women.[3] Faculty commitment is still based on the age-old practice of paying for the services of one while benefitting from the work of two – a man and his wife. Such a supposition is an anachronism in the 21st century with women entering waged labor in record numbers and dual-career families the norm. By and large, working women continue to have primary responsibility for children, elders, and housework. Thus the time beyond the 40-hour workweek that can be devoted to professional endeavors is often more limited for women than men.[4] These competing demands can cause acute problems for women in academic medicine where the period of peak career obligations coincides with childbearing and early child rearing.

Complicating this picture, career demands have grown for all workers over the last 30 years. Americans work six more weeks per year than we did two decades ago and eight more than the average European. In fact, US workers are putting in more hours per year than in any other country across the globe.[5]

"Commitment creep" only intensifies the difficult decisions women academics must make between work, on the one hand, and private interests and obligations, on the other.

Second, traditional system processes facilitate ongoing discrimination against women and minorities, however inadvertent or subtle.[6] Decision-making in academic medicine is too often undemocratic, lacking in transparency, and based on veteranism and cronyism, resulting in access to fewer resources-space, startup funds, support staff – and more clinical and teaching expectations for women faculty.[7] As Tobias, Urry and Venkatesan note in *Science*, "To be sure, women need to better understand the mechanisms of hiring, funding, and promotion; that is, how to play the game. But the game itself has to be purged of cloning, patronage, and outright discrimination if transparency in hiring and promotion is to become the rule."[8]

Third, system norms continue to reinforce a narrow range of values, given that top leadership in academic medicine remains primarily white male. Women and minorities are often underrepresented on high-level committees and other decision-making bodies, rendering them voiceless on important procedural issues and policy decisions. Their experiences are not brought to bear on the critical issues of how medicine should be framed and practiced, and how research and teaching must change to meet the demands of a more diverse patient and student population. Career "gendering" makes this lack of diversity even more acute in some departments, given that women are still concentrated in family medicine, pediatrics, and obstetrics/gynecology.

Academic medicine clings to these antiquated norms and arcane processes at its own peril; lack of diversity in leadership stifles innovation and creativity. Research findings reveal that heterogeneous teams consistently out-perform homogeneous ones.[9] Yet attracting women and minorities to academic medicine is becoming more and more difficult. Currently, the academy is perceived as having a chillier climate for women than does industry, serving to decrease the pool of women in academic careers.[10] If medicine is to attract the best and brightest, regardless of sex or ethnicity, concerted efforts to warm the climate and reconfigure work commitments to 21st century realities must be championed by senior leadership.

Responses

Clearly, the pipeline for women in academic medicine is

See "Challenges" page 3

"Challenges" continued from page 3

replete with holes, resulting in only a trickle of leaders emerging at the end. System retooling will be necessary to reach the "tipping point," often cited as 30%, when women in leadership positions are no longer isolated and easily marginalized. To begin this transformation, the AAMC has endorsed several approaches to improving the climate and opportunities for women in academic medicine. These include efforts to:

1. Emphasize faculty diversity by evaluating department heads on their successful development of women faculty;
2. Focus on the professional development needs of women faculty within the context of enabling all faculty to achieve their professional goals;
3. Determine which system practices differentially disadvantage women's professional development, such as rewarding unrestricted availability to work;
4. Increase the effectiveness of search committees to attract female candidates by providing insight into group processes and how candidates' qualifications are characterized and evaluated;
5. Support Women in Medicine programs and the AAMC Women Liaison Officer;
6. Monitor and report on the representation of women at senior ranks.[11]

Please join me at AMWA's Annual Meeting in February to discuss these recommendations, review model programs, and outline steps for transformation that you might use at your own institution.

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How can AMWA contribute?

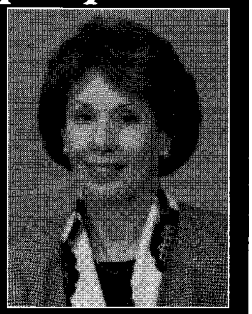
Equity+: Eliminating disparities in health care

Lynn C. Epstein, MD, FAPA, FAACAP

Amidst debates about controlling health care costs, the increasing numbers of uninsured, and concerns about patient safety, there is an alarming confounding variable: the unequal treatment provided to racial and ethnic minorities. As AMWA members, we know only too well the problems that continue to beset women as they strive to receive appropriate counseling for health maintenance, as well as accurate diagnoses and effective treatments. Add ethnic and racial variables to the mix and the problems become exponentially more complex.

In the spirit of collaboration, the American Medical Association (AMA) convened a Federation Task Force on Disparities in Healthcare in October, 2003. Clair M. Callan, MD, MBA, AMWA's VP of Finance and AMWA Foundation treasurer, and chair of the Science, Quality, and Public Health Standards committee for the AMA, organized the task force to address eliminating racial and ethnic disparities in health care.

President's perspective



Lynn C. Epstein, MD
AMWA President

After reviewing the patient level factors contributing to disparities, the group discussed practitioner level factors and health system level factors before moving on to identify tactical actions that the organizations could take. Agreeing that racial and ethnic disparities play an important part in our health care crisis, the group concluded that physicians can and should be catalysts to eliminate the disparities and to improve care. The group has pledged to continue to work together and to frame the recommendations into an organized plan of action.

A brief summary from the meeting follows:

- Risa Lavizzo-Mourey, MD, MBA, President and CEO of the Robert Wood Johnson Foundation, emphasized the need to collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and where possible, primary language. She also emphasized the need to include measures of racial and ethnic disparities in performance measurements so that we can monitor progress towards the elimination of health care disparities.
- Georges C. Benjamin, MD, FACP, Executive Director of the American Public Health Association, used a case study to show that comprehensive quality care could reduce disparities and emphasized the importance of collaboration between patients and practitioners.
- Marsha Lillie-Blanton, DrPH, Vice-President of the Kaiser Family Foundation, discussed the potential sources of disparities and how physicians might address them.
- Helen Burstin, MD, MPH, Director of the Center for Primary Care Research, suggested potential reasons behind the existence of disparities and possible ways that we might address them.
- In the discussion facilitated by John C. Nelson, MD, MPH, FACOG, FACPM, AMA Past President and Chair of the IOM Committee on Disparities and President-Elect and Executive Committee Member of the American Medical Association, the consensus emerged that:
  - Our purpose is to eliminate, not reduce disparities.
  - Data on race and ethnicity should be included as health markers.
  - There should be more focused research.
  - There should be a marked increase in awareness of the issue among our colleagues to include workforce issues.

As the Federation Taskforce prepares for its next meeting, I invite you to write to the editor with your opinions and suggestions for how AMWA can contribute to the elimination of racial and ethnic disparities in health care.

Lynn C. Epstein, MD

AMWA advocacy

Save Women's Lives

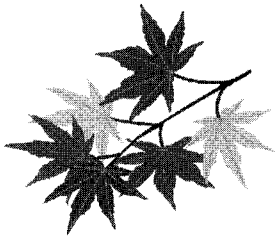
MARCH FOR WOMEN'S LIVES

SUNDAY-APRIL 25, 2004

WASHINGTON, DC

AMWA is a co-sponsor of the March for Women's Lives that will take place in Washington, DC, on Sunday, April 25, 2004. Join us as we demonstrate our support for a woman's right to choose safe, legal abortion, and birth control.

For information and to sign up:
www.marchforwomenslives.org
or contact: mkissell@amwa-doc.org



Visit Japan with AMWA

Diane Helentjaris, MD, AMWA's President in 2004, has selected Tokyo, Japan, and the MWIA International Congress as her President's Trip in 2004.

Join Diane and women physicians from around the world at the 26th International Congress of the Medical Women's International Association – "Medicine in a New Life Style - Education, Research and Practice" – in Tokyo, July 28 to August 1, 2004.

You can represent AMWA as a Delegate to the Congress. Request a brochure and registration from Marie Glanz at the national office and join other AMWA Delegates at Congress medical meetings and assemblies. Email: mglanz@amwa-doc.org; phone: 703-838-0500 (ext. 3305).

AMWA | *The President's Trip 2004* MWIA International Congress July 28-August 1, 2004 Tokyo, Japan

RHI news

RHI staff attended three national conferences in November: the Association of American Medical Colleges (AAMC), the American Public Health Association (APHA), and Sistersong. The AAMC Annual Meeting was held November 7-12 in Washington, DC, and attended by medical school deans, administrators, and faculty. RHI both exhibited and hosted a well-received session presented by Carolyn Westhoff, MD, of Columbia University, and Cathy Lazarus, MD, of Tulane University. The session showcased the *RHI Model Curriculum* and strategies for its integration into medical school curricula. Many members of the audience expressed enthusiasm about the Curriculum and the upcoming release of the 2nd edition, as well as the newly released Educational Tools. A medical student in the audience, Megan Sneed, described her experience using the *RHI Model Curriculum* to evaluate the course and content offerings at the University of Missouri Kansas City School of Medicine. Following the evaluation of UMKC's existing curricula, Megan was able to advocate effectively for inclusion of the content in the Curriculum that was not currently being covered.

On November 13-16, RHI staff attended a national conference on Women of Color Reproductive and Sexual Health and Rights organized by the SisterSong Women of Color Reproductive Health Collective in Atlanta, GA. The conference brought together over 500 activists to discuss and develop strategies for improving the reproductive health of women of color in the US and to celebrate the achievements of women of color who have worked on sexual and reproductive health and rights issues. The Collective, formed in 1997, is a network of local, regional, and national grassroots agencies representing women of color in the US working to educate women of color and policy makers on reproductive and sexual health and rights, and towards the access of health services, information, and resources that are culturally and linguistically appropriate.

RHI also recently traveled to San Francisco to exhibit for the first time at the APHA Annual Meeting, attended by over 15,000 public health professionals. This was an excellent venue for RHI to showcase its materials, and the exhibit received great support from interested conference attendees. APHA was also an excellent opportunity for RHI staff to connect with others doing similar work both domestically and internationally.

RHI's newest project is ready to provide presentations on adolescent reproductive health!

On October 18, 2003, nine physicians attended an information-packed training session in Atlanta, GA, for the Adolescent Reproductive Health Education Project (ARHEP). ARHEP is a unique project designed to increase awareness and knowledge about adolescent reproductive health care among physicians, advanced practice clinicians, medical students, and other health care professionals. The project is being piloted in Georgia, which has the sixth highest teen birth rate in the nation. In addition, Georgia is also one of the ten highest ranked states for reported cases of sexually transmitted infections (STIs), including gonorrhea and chlamydia.

ARHEP is a collaboration between RHI, *Physicians for Reproductive Choice and Health*® (PRCH), the Jane Fonda Center, and the Georgia Campaign for Adolescent Pregnancy Prevention. Over the next six months, RHI and PRCH faculty will deliver up to 18 educational programs to audiences from a variety of settings, such as conferences and grand rounds, in any region throughout Georgia. ARHEP presentations include: Minors' Access to Reproductive Health Care in GA: The Legal Framework, Effective Communication between Health Care Providers and Adolescents: "Best Practices," Adolescent Reproductive Health Service Delivery: Translating Theory into Practice.

RHI can support presentations (while funds last) in Georgia. Please contact Tori Lallemont, RHI Medical Education Coordinator, at 703-838-0500, e-mail: tlallemont@amwa-doc.org to schedule a program.

A patient teaches the most valuable lesson

Wendy E. Braund, MD, MSEd,
Resident Representative to
AMWA Board

Recently I was having one of those, "Why did I EVER go into medicine?" moments. And then I remembered EJ, my first patient.

I was a third year medical student just beginning my internal medicine rotation at a non-emergent health care clinic for indigent and low-income city residents.

Despite assurance from EJ that he had been wearing his clonidine patch for hypertension, his blood pressure was so high that I repeated the procedure three times. Indeed, the patch was on his arm. I checked the dosage. He had watched his diet, was not overweight, and did not seem to be suffering from "white coat syndrome."

I was too new to patient care to dismiss EJ as noncompliant or admit to my preceptor that I didn't have the answer.

Suddenly, I had an idea. I asked EJ to show me how he put on the cellophane patch. He took the adhesive bandage out of the packet and carefully applied it to his opposite shoulder after peeling off his current one. As he crumpled up the wrapper, a small white disc fell to the floor. It was the clonidine patch! Apparently no one had explained to EJ that it was necessary to put that bit of paper (the active ingredient) UNDER the bandage in order to get his medicine. He really had been "following doctor's orders"; he just didn't understand them completely.

That interaction reaffirmed my decision to become a doctor: to help people. The simple act of really listening to my patient and enlisting his aid solved his health care issue.

As residents, we are frequently overwhelmed by the multitude of tasks at hand and responsibilities we carry. Who has time to actually TALK with patients, much less their families? When I feel like that, I pause and remember EJ, the patient who taught me one of the most valuable lessons I learned in medical school.

Creating a New Mold

Equality for Females in the Medical Profession

Allison Leigh Speer, MSII, University of Southern California, Keck School of Medicine

January 2003. The smell of sterilization fills my nostrils as I take a deep breath and look around the operating room. One surgeon is delicately operating the robot, which is slowly removing an anterior paraspinal mass from within the patient's thorax. The other surgeon is busy scrutinizing the video screen. One scrub nurse stands next to the patient, occasionally adjusting the robot's arms while the other scrub nurse stands a few feet away, attentively watching the video screen. The anesthesiologist sits by the patient's head, surrounded by complicated equipment; the robot operator scurries about the room, fiddling with cords here and there. A couple of residents and another physician stand talking in the back of the OR, while an intern and a first-year medical student eagerly observe. The registered nurse sits in the corner, writing notes and occasionally getting up to retrieve something for the surgeons or the scrub nurses.

Two surgeons, two scrub nurses, an anesthesiologist, a robotic equipment operator, a registered nurse, a couple of residents, a physician, an intern, and a first-year medical student. How many of the people in that room were women? Only two out of the twelve: The registered nurse and the first-year medical student, me.

The Journal of the American Medical Association (*JAMA*) reports that in the year 2000, only 38% of all residents were women. The most popular specialties among these women were internal medicine (22.9% of all female residents in 2000), pediatrics (13.6%), family practice (13.3%) and obstetrics and gynecology (8.9%). Women made up 69.6% of all residents (male and female) in obstetrics and gynecology and 65.2% of all residents in pediatrics. However, only 4.7% of all female residents entered into surgery (22.6% of all residents entering that field), and a mere 0.6% of all female residents chose the field of orthopedic surgery (only 8.1% of all residents entering that field). This data suggests that women are severely underrepresented in the surgical specialties.

What can we, as medical students, do to help eliminate disparities in health care? Claudia Fegan, MD, past president of Physicians for a National Health Plan (PNHP), told us at the 87th Annual AMWA Conference that we must "guard against stereotyping." Do not force yourself into an antiquated female mold. Do not force yourself into an archaic male mold. Create a new mold: a stronger, smarter, and better *female* mold. Make, be, and live the mold that is right for you, both professionally and personally. It is only when obsolete stereotypes are forgotten and when the roles of women and men in the workforce, in the home, and in society have been reconstructed, that equality will be realized.

AMWA branch and chapter updates

Region V news:

Baylor College of Medicine's AMWA chapter revitalized itself this past semester. The group started with a "wine and cheese" introductory meeting in September where students from all classes welcomed first year students and learned about the chapter's plans for the year. In October, AMWA fourth years hosted a residency-planning workshop, giving sage advice on how to navigate clinics, electives, and residency applications. Later that month, the chapter also hosted its most popular event, our "Women in Medicine Banquet." Our leading women attending physicians spoke about their experiences in medicine and achieving a balanced life. Finally, this semester's lunchtime lectures included presentations about domestic violence screening and the partial-birth abortion ban. Overall, Baylor's AMWA is off to a new beginning! Please contact Kimberely Kho for information (kk126602@bcm.tmc.edu).

Region V Activities

This past fall the AMWA chapter in San Antonio, TX, had their 2nd annual Powder Puff Football game. We gathered local business donations, made event t-shirts, sold tickets (for the game and deli lunch), and held a raffle for the exciting game between the first and second year women. We had plenty of spirited male cheerleaders and faculty supporters cheering from the sidelines. The game ended in a tie... and a rematch is scheduled for the spring! The proceeds went towards chapter initiatives such as supporting the Battered Women's Shelter and monthly theme meetings. In addition, $500 was donated to the Susan G. Komen Foundation for local prevention of breast cancer and mammography services for San Antonio women. Powder Puff is a great way to include the medical community in AMWA activities and sponsor a women's health cause! If you are interested in planning a similar event, please send questions to Kristi Tough (tough@uthscsa.edu).

Send information about your chapter activities to Francesca Cimino, MSIII, University of Southern California (fcimino@usc.edu).

An academic model

An integrated approach to tackling HIV in Kenya

Gillian Baty, MSIV, University of Utah School of Medicine, National Student Coordinator

She searched for me after rounds, I think because I had asked kindly how her husband was before the morning flurry of activity. I then noticed that she was pregnant. My first thought was for the unborn child, the one in this family who had a chance of staying negative. The ELISA results on her husband showed no confirmatory Western blot, but Samuel had the look of one dying from AIDS.

I spent a month in western Kenya doing an exchange rotation with Moi University. Although I was there to learn about internal medicine in Kenya, the biggest impression left on me was the devastation that HIV has wracked on Kenyan families. Count the deaths on our watch. Count the widows. While taking a history, we asked, "Are you married?" "Yes, and how many wives do you have?" We could have asked how many children would be left behind, as well. The individual stories are heartbreaking; the societal toll is mind numbing.

A Kenyan woman receives prenatal care at a Moi University clinic.

There are many good attempts in Kenya to deal with this tragedy. People realize that women are key to their family's health, so many programs target women. Men who have the virus are lucky if they infect their pregnant wife, for there is a program that provides anti-retroviral drugs (ARV's) to pregnant women and their families. After an awkward conversation with Samuel's wife, I learned that she thought he had the virus. She was getting pre-natal care, therefore had been tested, and they had not been intimate for 7 months. I advised her to be re-tested immediately. In some ways, Samuel's only hope was if she was positive; however, more than 90% of the families who have a positive member cannot afford even the generic ARV's that have recently become available in the country.

Collaboration between Kenyan and US medical schools started a small pilot project that has grown into one of Kenya's largest comprehensive care system for HIV-infected patients and their families – An Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH). Realizing that a one-dimensional approach, such as isolated medical treatment, would do little to save lives, a three-prong approach was introduced. First, nutrition: An individual with malnutrition cannot mount an immune response, so they are developing a demonstration farm to grow nutritious food, enlisting the help of nutritionists to write prescriptions for HIV patients' nutritional needs, and educating families, especially widowed women, in agricultural techniques. Second, education: They collaborated with the traditional birth attendants to teach HIV concepts to villagers, referring patients for testing, and administering ARV's perinatally. Third, financial: HIV often compounds the issues of poverty or plunges a family into poverty. This aspect models a program that succeeded in moving street children back into families and training these families for economic independence.

These collaborations will serve as outstanding models for developing comprehensive programs elsewhere in the world. Through the efforts of AMPATH, Samuel and his family will have a better chance of their life's story being a happy one.

Women in medicine

Mary Ellen Avery, MD, with a half-century of medical and humanitarian credentials established worldwide, will receive The Foundation for the History of Women in Medicine Alma Dea Morani, MD, Renaissance Woman Award.

WPC Liaison, **Carol D. Berkowitz, MD, FAAP,** was named president-elect of the American Academy of Pediatrics (AAP) at the AAP's National Conference and Exhibition (NCE) in early November. At the close of the 2004 NCE, she will be sworn in as president. She will be the AAP's third woman president.

Barbara Bierer, MD, has been elected president of the Association for the Accreditation of Human Research Protection Programs. Dr. Bierer is senior vice president for research at Brigham & Women's Hospital in Boston, MA.

In October, **Willarda Edwards, MD, MBA,** chair of the WPC Governing Council was selected president-elect of The Maryland State Medical Society (Med Chi). Dr. Edwards will take office on October 16, 2004.

Lila Stein Kroser, MD, FAAFP, was elected vice-president of the Pennsylvania Medical Society. Dr. Kroser is a past-president of AMWA and the Medical Women's International Association (MWIA).

Becky Miller, MD, will be honored with the Excellence in Medicine Award at the Lorraine Jackson Foundation's upcoming Awards and Scholarship Gala.

Mary D. Nettleman, MD, MS, FACP, professor of internal and preventive medicine, is the new chair of the department of medicine at Michigan State University College of Human Medicine in September 2003.

The American Board of Thoracic Surgery elected its first female officer at its October 11, 2003, meeting. **Carolyn E. Reed, MD,** a thoracic surgeon from Charleston, SC, was elected vice chair. She will serve in this position for two years (2003-2005) followed by two years as chair (2005-2007). Dr. Reed was also the first female director nominated to the board (in 1997).

Barbara H. Roberts, MD, FACC, authored *How to Keep from Breaking Your Heart: What Every Woman Needs to Know About Cardiovascular Disease* (to be published by Jones & Bartlett Publishers in January 2004). Dr. Roberts is director of The Women's Cardiac Center at the Miriam Hospital in Providence, RI, and president of the Rhode Island Medical Women's Association (Branch 26 of AMWA).

Roberta G. Rubin, MD, donated $30,000 to the AMWA Foundation's Janet M. Glasgow Fund. For a limited time, the Glasgow Awards will be named Glasgow-Rubin Achievement Certificates and the Glasgow-Rubin Essay Award.

Carol Tacket, MD, internationally acclaimed physician/ scientist and a leader in the prevention of infectious diseases, will receive the National Board for Women in Medicine Marion Spencer Fay Award.

Ann Ruth Turkel, MD, president of the American Academy of Psychoanalysis and Dynamic Psychiatry, is guest editor of the Spring 2004 *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*. The issue's theme is Women and Society. Dr. Turkel is also a member of the Committee on Women of the American Psychiatric Association.

Carolyn Westhoff, MD, recently published an article on Emergency Contraception in the November 6 edition of the *New England Journal of Medicine* (*NEJM*.2003;349:1830-1835).

HHS designates six new national Centers of Excellence in Women's Health

The U.S. Department of Health and Human Services (HHS) announced the creation of six new National Centers of Excellence in Women's Health, model academic health centers that provide integrated and comprehensive women's health services across the United States serving as *one-stop shopping* models targeted to the health care needs of women. HHS will provide nearly one million dollars to support the six new centers, some of which will focus on rural women's health.

The new centers are at the Virginia Commonwealth University, University of Mississippi Medical Center, Brown University, University of Minnesota, University of Arizona and Oregon Health and Science University.

"These new centers of excellence provide innovative solutions for women seeking the best comprehensive care," HHS Secretary Tommy G. Thompson said. "They are part of our continuing commitment to bring quality health care to women, including minority and under-served women across the nation. These new centers will help to develop effective approaches for improving women's health that can be adopted in communities throughout America."

More information on the National Centers of Excellence in Women's Health is available at www.4woman.gov/coe.

AMWA calendar

February 5-8, 2004
AMWA's 88th Annual Meeting, *The AMWA Prescription: More Than Health...Well-Being*, San Diego, CA

March 2004
Incorporating Reproductive Health Care into the Medical Curriculum in Developing Countries
Co-hosted by RHI and Commonwealth Medical Association Trust, Delhi, India

April 2004
AMWA-RHI MAEP Faculty Meeting, NAF/MSFC Meeting

April 25, 2004
March for Women's Lives, Washington, DC

June 24-26, 2004
AMWA's Interim Meeting and Lobby Day, Washington, DC

June 25, 2004
AMWA's 4th Annual International Women in Medicine Hall of Fame Gala, Washington, DC

July 28-August 1, 2004
2004 President's Trip/MWIA's 26th International Congress, *Medicine in a New Life Style – Education, Research and Practice* Tokyo, Japan

January 27-30, 2005
AMWA's 89th Annual Meeting, Washington, DC

AMWA branches are encouraged to submit activities and meeting dates for the AMWA Calendar.

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